

Exhibit 2

**UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION**

Alliance for Hippocratic Medicine, *et al.*,

Plaintiffs,

v.

U.S. Food and Drug Administration, *et al.*,

Defendant.

Case No. 2:22-cv-00223-Z

DECLARATION OF JASON LINDO

I, Jason Lindo, Ph.D., pursuant to 28 U.S.C. § 1746, declare under penalty of perjury that the following is true and correct.

I. Professional Credentials and Experience

1. I provide the following facts and opinions as an expert in the field of economics, policy evaluation, and reproductive health care. I am a Professor of Economics and the Ray A. Rothrock '77 Senior Fellow at Texas A&M University. Prior to my appointment as full professor on September 1, 2018, I was an Associate Professor of Economics at Texas A&M beginning in 2013.

2. I have been a Research Associate at the National Bureau of Economic Research (NBER) since 2014, and before that, I was a Faculty Research Fellow at NBER beginning in 2011. NBER is the nation's leading nonprofit economic research organization, studying a wide range of topics, including the effects of various public policies.

3. I received a B.A. in economics in 2004, an M.A. in economics in 2005, and a Ph.D. in economics in 2009—all from the University of California, Davis.

4. I have published 28 research articles in peer-reviewed journals and books. I am a Specialized Co-editor of *Economic Inquiry*, in which role I determine whether the journal should publish submitted papers in the areas of health economics, public economics, and policy evaluation.

5. My research interests include health economics and issues concerning youth, including the economic effects of abortion and contraceptive policies. My recent and ongoing work is especially focused on documenting the effects of changes in access to reproductive healthcare.

6. I have taught courses on empirical research methods at the undergraduate and graduate levels for 13 years. These courses focus on the quantitative methods that economists use to evaluate the causal effects of government programs and other interventions, how these methods overcome problems that often plague correlational analyses, and the conditions under which these methods are appropriate. They also cover how these methods are used in the context of research on reproductive health care.

7. A copy of my curriculum vitae setting forth my experience, education, and credentials in greater detail is attached as **Exhibit A**.

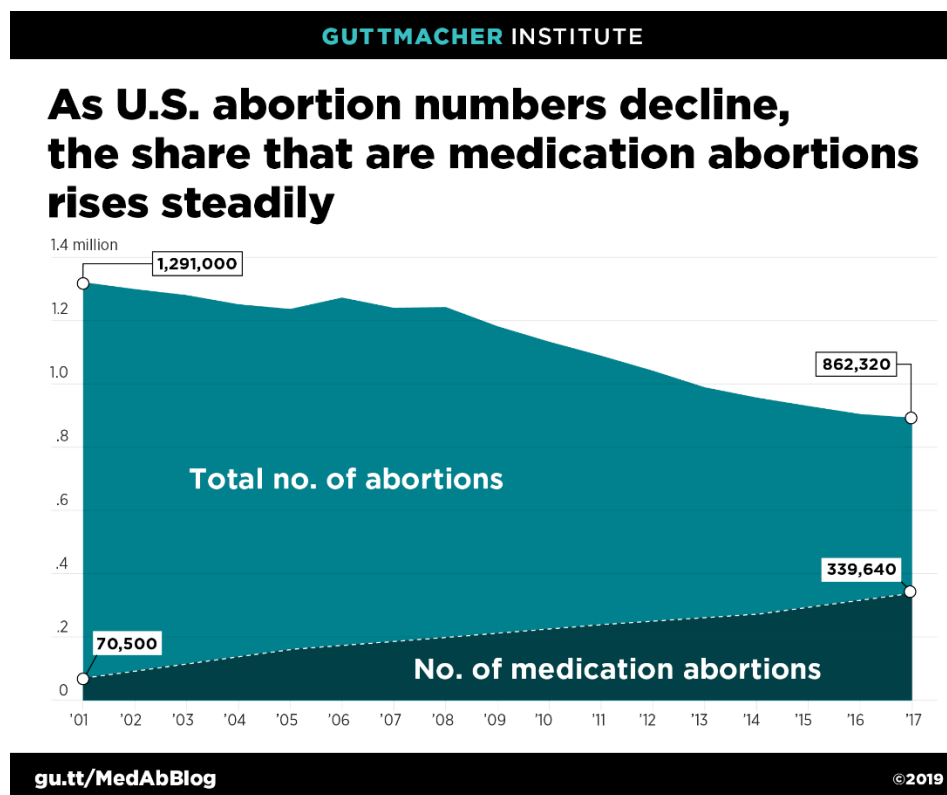
II. Summary of Findings Below

8. Individuals seeking abortions in the United States come from an extremely diverse set of backgrounds. Nonetheless, a substantial majority have incomes below the federal poverty line, a majority have prior children, and a majority are neither married nor cohabitating.

9. Individuals report seeking abortions for many different reasons and combinations of reasons. The most frequently cited reasons, which have substantial overlap, include: financial insecurity, poor timing and/or not being ready, educational and career plans, problems associated

with their partners, concerns about their existing children, and concerns about health that would arise from continuing the pregnancy.

10. The Food and Drug Administration approved mifepristone for use in 2000. Since 2000, the overall number of abortions in the United States has decreased substantially. Though the number of abortions is decreasing, the proportion of people who do obtain abortions who opt for a medication abortion is increasing. This is shown in the figure below (and discussed in greater detail in a subsequent section).



11. The share of abortions that are medication abortions has grown especially quickly in recent years. Today, over 50 percent of abortions are medication abortions.

12. As detailed below, informational resources provided to abortion patients typically highlight that the choice to have a medication abortion or a surgical abortion is a personal decision, and that there are many reasons why people with different preferences may choose one

method over the other.¹ These informational resources often include among the advantages of medication abortion such factors as: it is less physically invasive (i.e., eliminates the need to have a procedure in which a doctor inserts surgical instruments into the uterus); it is more private; and it allows greater control over when, where, and with whom the abortion occurs. Surveys of patients presenting for abortion at clinics where they could obtain either a medication abortion or a surgical abortion also highlight these factors, among many others, as important in influencing people's preferences for medication abortion.

13. People may also obtain a medication abortion, rather than a surgical abortion, because medication abortion is the only option offered by a provider that is accessible to them. This is particularly relevant given that 31 percent of clinics providing abortion *only* provide medication abortion and because people seeking abortions, particularly surgical abortions, face many obstacles to obtaining care, including obstacles related to travel. It is also relevant because medication abortions are available, at least in some circumstances, via telehealth, whereas surgical abortions are not.

14. The American College of Obstetricians and Gynecologists also highlights that certain medical conditions may make medication abortion preferable.²

15. Given the large number of abortion patients who have medication abortions and their clearly articulated needs and/or informed reasons for doing so, removing medication abortion as an option would represent a shift that is substantially detrimental to a very large share of individuals seeking abortions. It would prevent many individuals from choosing the method

¹ Here and below, I use “medication abortion” to refer to the typical practice used in the United States of administering mifepristone to stop a pregnancy from progressing followed by misoprostol to expel the contents of the uterus.

² American College of Obstetricians and Gynecologists' Committee on Practice Bulletins—Gynecology, Society of Family Planning. Medication Abortion Up to 70 Days of Gestation: ACOG Practice Bulletin, Number 225. *Obstet Gynecol.* 2020 Oct;136(4):e31-e47. doi: 10.1097/AOG.0000000000004082. PMID: 32804884.

that is best for them given their own health or other needs and/or preferences. Others will be made worse off still because some abortion providers and locations will no longer be available to them—i.e., if their closest or preferred clinic is only equipped to provide medication abortion. As a result, for some of these individuals, financial and logistical constraints will delay their ability to obtain an abortion. For others, it will make them unable to obtain an abortion.

16. Those seeking abortions will also be made worse off by the broader effect on the landscape for abortion care. Though the effect will be less than one-for-one, the demand for surgical abortions will increase if people can no longer obtain medication abortions. Many factors will prevent abortion providers from meeting a large and sudden increase in demand for surgical abortions, including infrastructure and staffing. As a result, the increase in demand for surgical abortions is expected to increase waiting times for *all* individuals seeking abortions (not just those with a preference for medication abortions).

17. Abortion providers often provide many other forms of health care, including contraception, sexually transmitted infections (“STI”) screening, clinical breast exams, etc. A surge in demand for them to provide surgical abortions could impair their ability to provide such care, which could have detrimental impacts on their other patients.

18. Increased waiting times for abortion will cause delays such that some people will have abortions at later stages of pregnancy and some will be prevented from obtaining abortions at all. For those who have delayed abortions, the financial consequences can be devastating because: (i) a large share of individuals seeking abortion have low incomes, (ii) the cost of an abortion very early in pregnancy is already so high that it would be classified as a catastrophic health expenditure³ for most *middle*-income individuals, and (iii) the cost of obtaining an

³ The term “catastrophic health expenditure” generally refers to circumstances in which the out-of-pocket cost of a health service is above 40 percent of nonsubsistence income, where nonsubsistence income is income minus the

abortion increases significantly with the gestational age of the fetus. Delayed abortions may also increase the risk that a person's privacy is compromised in a way that harms them, *e.g.*, by increasing the likelihood that their pregnancy becomes apparent to others. Delays in abortion access will also place people at a greater risk of complications; while abortion is generally considered by the medical community to be extremely safe at any point and also to be safer than childbirth, the risks increase as pregnancy progresses.⁴

19. Increased waiting times will also prevent some people from having an abortion altogether. This will cause heightened health risks associated with continuing the pregnancy to childbirth.⁵ Rigorous quantitative research detailed further below indicates that it will also reduce their earnings, increase poverty and/or depth of poverty, increase other measures of financial distress, reduce levels of education, and increase domestic violence.

20. Rigorous quantitative research also indicates that there will be extensive effects on the children of people who seek but are unable to obtain an abortion. As a result of the impacts on their parents, these children are expected to do worse in school (lower test scores and increased grade repetition), to have more behavioral and social issues, and ultimately to attain lower levels of completed education. They are also expected to have lower earnings as adults, poorer health, and an increased likelihood of criminal involvement.

minimum amount that is needed to pay for basic necessities (food, childcare, health, housing, transportation, taxes, clothing, and personal items). It is a commonly used measure of the severity with which the expenditure will impoverish a household.

⁴ See, *e.g.*, Bartlett LA, Berg CJ, Shulman HB, Zane SB, Green CA, Whitehead S, Atrash HK. Risk factors for legal induced abortion-related mortality in the United States. *Obstet Gynecol.* 2004 Apr;103(4):729-37. doi: 10.1097/01.AOG.0000116260.81570.60. PMID: 15051566; Frick AC, Drey EA, Diedrich JT, Steinauer JE. Effect of prior cesarean delivery on risk of second-trimester surgical abortion complications. *Obstet Gynecol.* 2010 Apr;115(4):760-764. doi: 10.1097/AOG.0b013e3181d43f42. PMID: 20308836; Grimes DA, Schulz KF, Cates WJ Jr. Prevention of uterine perforation during curettage abortion. *JAMA.* 1984 Apr 27;251(16):2108-11. PMID: 6708260.

⁵ See, *e.g.*, Raymond EG, Grimes DA. The comparative safety of legal induced abortion and childbirth in the United States. *Obstet Gynecol.* 2012 Feb;119(2 Pt 1):215-9. doi: 10.1097/AOG.0b013e31823fe923. PMID: 22270271.

21. Ceasing to allow medication abortion will also impact the lives of the many individuals who choose to own, operate, and work for businesses that provide abortion care because it restricts their ability to provide care to people in a manner that is consistent with their medical judgment about what is the most appropriate method for providing the health care sought. It is also important to note that “burnout” is frequently cited among those who stop working for abortion providers (and for health care providers generally), and heightened stress may occur when providers are operating at their full capacity and trying to expand that capacity, or when they are otherwise forced to provide health care in a manner that does not align with their medical judgment and/or with their patients’ needs and preferences. Moreover, for at least some providers and clinics who only offer medication abortion, eliminating medication abortion would eliminate their ability to provide abortions altogether, and for others it would require them to undertake substantial changes to their practice.

22. Many of these issues clearly concern the broader public. Among the issues not touched on above, in the event medication abortion were to become unavailable, the broader public is expected to face: increased health care costs due to increased health care utilization; increased taxes due to increased reliance on public assistance and social safety net programs; and general exposure to poverty, which is pervasive, hard to escape, and often persists from one generation to the next.

23. Overall, eliminating medication abortion will limit people’s ability to make choices about their life and health, including how and when to have children. Those with limited economic resources, privacy and safety concerns, and women of color are disproportionately likely to be affected in this manner. This will have far-reaching impacts on individuals seeking abortion and their families; those who own, operate, and work for abortion providers; and the

broader public.

24. These are the effects that can be expected if medication abortion ceases to be available in the United States, based on the extensive scientific literature spanning various disciplines.

III. Background

25. In this section, I provide background on individuals seeking abortions in the United States. An important caveat to this background, however, is that, in the wake of the Supreme Court overturning *Roe v. Wade*, the landscape has changed in ways that researchers are still in the process of documenting.

III.A. Background on Individuals Seeking Abortion Generally

26. Based on 2014 abortion rates: 23.7 percent of women aged 15-44 years in 2014 were expected to have an abortion by the time they turned 45 years old (assuming 2014 abortion rates were to continue through the time they turned 45 years old);⁶ 12 percent of people obtaining abortions were less than 20 years old; and 60 percent were in their 20s.⁷ People of color are disproportionately represented among those obtaining abortions. In terms of race, 27.6 percent of people obtaining abortions in 2014 were Black, even though only 14.9 percent of US women aged 15-44 were Black.⁸ In terms of ethnicity, 24.8 percent of individuals obtaining abortions in 2014 were Hispanic, even though only 20 percent of US residents were Hispanic.⁹

27. A substantial majority of those seeking abortions have relatively low incomes.¹⁰ In 2014, half had incomes less than the federal poverty line and three-quarters had incomes less

⁶ Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 AM. J. PUB. HEALTH 1904, 1907 (2017).

⁷ *Id.* at 1906.

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.* at 1906–1907.

than 200 percent of the poverty line.^{11,12} Compounding their financial difficulties, 59 percent had previously given birth and 55 percent were neither married nor cohabiting.¹³ Moreover, 55 percent reported having experienced at least one “disruptive life event” during the preceding 12 months, where disruptive life events include the death of a close friend or family member, having a family member with a serious health problem, having a baby, separating from a partner, having a partner arrested or incarcerated, being unemployed for at least one month, falling behind on rent or a mortgage, or moving two or more times.¹⁴

28. Individuals report seeking abortions for many different reasons and combinations thereof. Most (64 percent) report multiple and/or overlapping reasons.¹⁵ 40 percent report financial concerns.¹⁶ 36 percent report concerns about the timing and/or not being ready.¹⁷ 20 percent report concerns that continuing the pregnancy would interfere with their future goals, usually involving school (14 percent) and/or career plans (7 percent).¹⁸ 31 percent report varied concerns associated with their partner, including poor and/or unstable relationships, a lack of support, and/or that the man involved in the pregnancy is the “wrong guy” or is abusive.¹⁹ Individuals with abusive partners report concerns that continuing an unwanted pregnancy will

¹¹ In 2014, the Federal Poverty line was \$12,316 for a single adult, \$16,317 for a family with one adult and one child, and \$19,073 for a family with one adult and two children. The Federal Poverty line was \$15,853 for family of two adults, \$19,055 for a family with two adults and one child, and \$24,008 for a family with two adults and two children. CARMEN DENAVAS-WALT & BERNADETTE D. PROCTOR, U.S. CENSUS BUREAU, INCOME AND POVERTY IN THE UNITED STATES: 2014 43 (2015).

¹² Jones, *supra* note 6, at 1906.

¹³ *Id.*

¹⁴ Rachel K. Jones & Jenna Jerman, *Characteristics and Circumstances of U.S. Women Who Obtain Very Early and Second Trimester Abortions*, 12 PLOS ONE 1, 3–4 (2017).

¹⁵ M Antonia Biggs, H. Gould & Diana Greene Foster, *Understanding why women seek abortions in the US*, 13 BMC WOMEN'S HEALTH 29 (2013).

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

put them at greater risk by tethering them to their abuser.²⁰ 29 percent report concerns associated with their other children. 6 percent report concerns about their own health, including physical ailments and mental health problems that would be exacerbated by continuing the pregnancy.²¹ 5 percent reported reasons associated with drug, tobacco, or alcohol use.²²

29. An individual's ability to obtain an abortion depends on many factors beyond their control, including the availability of care, the amount of travel required, affordability, and state requirements such as waiting periods.²³ Survey data shows that among women who would have preferred to have obtained their abortions sooner in time, 59 percent report that delays occurred because it took time for them to make arrangements.²⁴ Consistent with this statistic, empirical evidence indicates that regulations that substantially increase the financial, travel, and/or logistical burdens of obtaining an abortion have a significant effect on abortion access.

III.B. Background on Medication Abortion

30. Since the Food and Drug Administration approved mifepristone (200 mg) for the medical termination of early intrauterine pregnancy in 2000, the number of medication abortions and the share of abortions that are medication abortions have grown consistently even though the number of abortions overall has fallen. The share of abortions that are medication abortions has grown especially quickly in recent years. Today, over 50 percent of abortions are medication abortions.

31. Data from both the Guttmacher Institute and the Centers for Disease Control and

²⁰ Karuna S. Chibber, M Antonia Biggs, Sarah C. M. Roberts & Diana Greene Foster, *The role of intimate partners in women's reasons for seeking abortion*, WOMENS HEALTH ISSUES, (2014).

²¹ M Antonia Biggs, H. Gould & Diana Greene Foster, *Understanding why women seek abortions in the US*, 13 BMC WOMEN'S HEALTH 29 (2013).

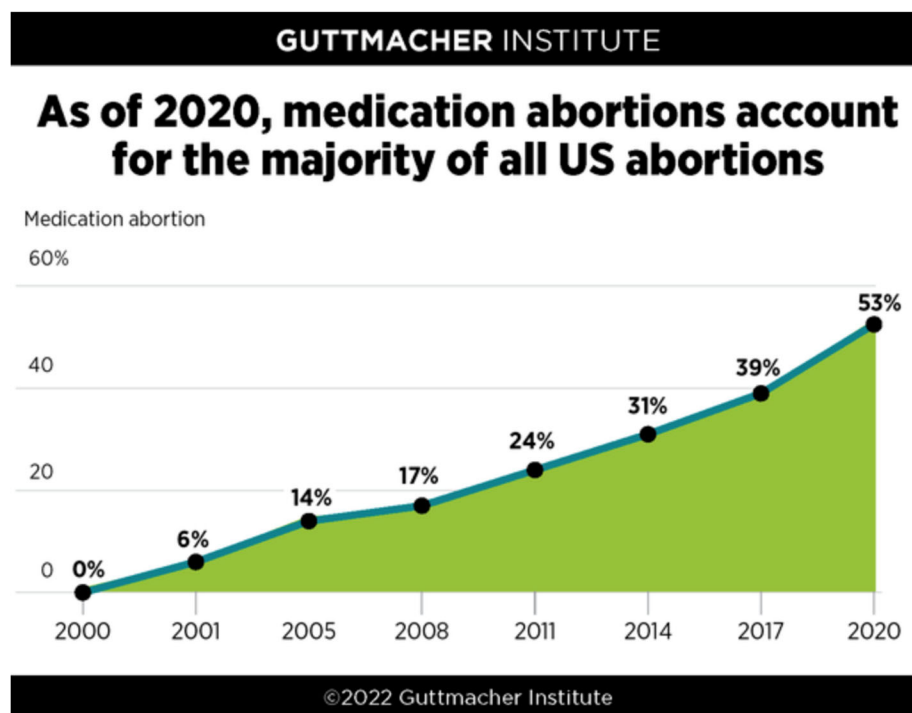
²² *Id.*

²³ NAT'L ACAD. SCI., THE SAFETY AND QUALITY OF ABORTION CARE IN THE UNITED STATES 12 (2018).

²⁴ Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 CONTRACEPTION 334, 335 (2006).

Prevention (CDC) support these statements. Data from both sources are commonly used among researchers (myself included) and are generally considered reliable. The Guttmacher Institute collects data on abortion incidence and service availability via surveys of all facilities known to have provided abortion services in the United States as a part of their Abortion Provider Census. The CDC collects aggregated data on abortion incidence based on requests to the central health agencies for the 50 states, the District of Columbia, and New York City.²⁵

32. The figure below from the Guttmacher Institute shows that the share of medication abortions—as a percentage of abortions overall—has grown over time.²⁶ It also shows that this share has grown especially rapidly in recent years.

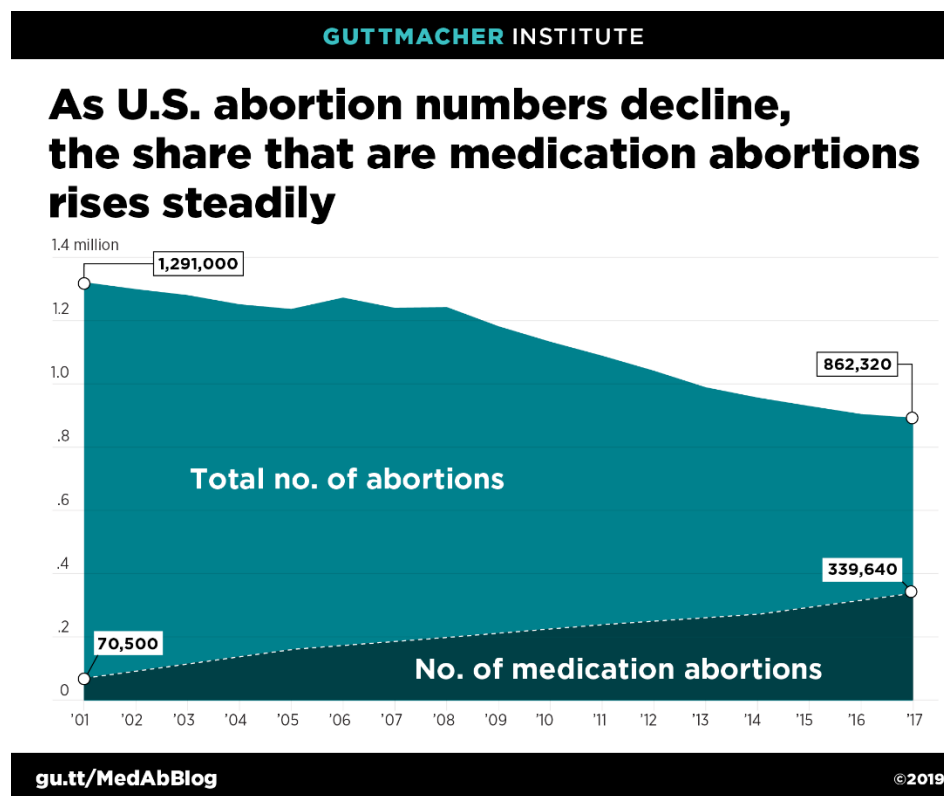


33. The following figure, which was shown above at ¶10, is based on Abortion

²⁵ My understanding is that the CDC requests data from New York City (apart from requesting aggregate data from the state of New York) because they recognize that New York City is so large (in population) that it can be particularly useful for researchers to have access to statistics for its residents.

²⁶ Rachel K. Jones *et al.*, *Medication Abortion Now Accounts for More Than Half of All US Abortions*, The Guttmacher Institute (February 24, 2022), <https://www.guttmacher.org/article/2022/02/medication-abortion-now-accounts-more-half-all-us-abortions>

Provider Censuses. It shows that the overall *number* of medication abortions grew from 2001 to 2017 even as the number of abortions overall declined over this period.



34. Subsequently published data shows a significant increase in the overall number of medication abortions between 2017 and 2020. In particular, that number grew from 339,650 to 493,320, representing a 45 percent increase.²⁷

35. CDC data for states reporting data corroborates these patterns. In 2020, 51.0 percent of abortions were defined as “early medical abortions” by the CDC (i.e., medication abortions at less than or equal to nine weeks gestation and typically involving the use of mifepristone followed by misoprostol).²⁸ The same CDC data also highlights a recent significant increase in the proportion of medication abortions, reporting that the percentage of all abortions

²⁷ Jones, RK, Kirstein, M, Philbin, J. Abortion incidence and service availability in the United States, 2020. *Perspect Sex Reprod Health*. 2022; 54(4): 128- 141. doi:[10.1363/psrh.12215](https://doi.org/10.1363/psrh.12215).

²⁸ Kortsmit K, Nguyen AT, Mandel MG, et al. Abortion Surveillance — United States, 2020. *MMWR Surveill Summ* 2022;71(No. SS-10):1–27. DOI: <http://dx.doi.org/10.15585/mmwr.ss7110a1>

performed by early medical abortions increased 22 percent from 2019 to 2020.²⁹

36. Medication abortions are especially prevalent as a share of abortions at earlier stages of pregnancy. At less than or equal to six weeks gestation, 67.9% of abortions are medication abortions.³⁰ At 7 to 9 weeks gestation, 58.7% of abortions are medication abortions.³¹

37. There are many differences between medication abortion and surgical abortion that may cause a person to obtain a medication abortion rather than a surgical abortion.

38. One simple reason that people may prefer medication abortion is access. *31 percent of clinics offering abortion provide only medication abortion.* As a result, for many people seeking abortions, surgical abortion providers are more difficult, and in some cases impossible, for the pregnant person to visit. Given that individuals seeking abortions report financial, logistical, and transportation-related challenges to obtaining care,³² some of these individuals may not be able to reach a surgical abortion provider and others may opt for the provider that presents fewer difficulties for obtaining a timely abortion. Along similar lines, people may prefer medication abortion because it is accessible to them via a telehealth visit whereas surgical abortion requires an in-person visit. The importance of access is underscored by extensive research documenting numerous obstacles (e.g., finding a facility, costs, travel, being turned away from a facility, etc.) that delay and/or prevent people from accessing abortion care.³³

²⁹ *Id.*

³⁰ *Id.*

³¹ *Id.*

³² See, e.g., Wingo, E., Ralph, L. J., Kaller, S., & Biggs, M. A. (2021). Abortion method preference among people presenting for abortion care. *Contraception*, 103(4), 269-275; White, K., Grossman, D., & Turan, J. M. (2016). Experiences accessing abortion care in Alabama among women traveling for services. *Women's Health Issues*, 26(3), 298-304; White, K., Turan, J. M., & Grossman, D. (2017). Travel for abortion services in Alabama and delays obtaining care. *Women's Health Issues*, 27(5), 523-529.

³³ See, e.g., Diana Greene Foster, *The Turnaway Study: Ten Years, a Thousand Women, and the Consequences of Having—or Being Denied—an Abortion* (2020); Wingo, E., Ralph, L. J., Kaller, S., & Biggs, M. A. (2021). Abortion method preference among people presenting for abortion care. *Contraception*, 103(4), 269-275. <https://doi.org/10.1016/j.contraception.2020.12.010>

39. Some people may also prefer a medication abortion because it is the only option offered by a provider that they are comfortable with, based on a history of other care they have received from that provider,³⁴ which might include general health care, gynecological care, prenatal or obstetric care, or many other types of care other than abortion services.³⁵

40. Organizations and health care providers seeking to educate people on abortion underscore the fact that preferences vary across individuals and that there are good reasons why—if given the choice—one might choose a medication abortion over a surgical abortion (or vice versa). Resources reviewing the pros and cons typically highlight that individuals may prefer a medication abortion based on factors such as: to avoid a procedure in which a doctor inserts surgical instruments into the uterus through the vagina; out of concerns for privacy; and because it gives them greater control over the when, where, and with whom the abortion occurs.³⁶

41. In terms of concerns about privacy, it is important to note that surgical abortions can require a patient to have an escort home, which may be undesirable for individuals who would prefer to maintain their privacy or those who cannot find an escort they are comfortable with at the same time they can obtain a surgical abortion. Medication abortions may also help patients maintain their privacy because they require less time in the clinic (or no time in the clinic for individuals obtaining medication abortion via telehealth).

42. The ability to spend less time at the provider may also be important to individuals

³⁴ Shochet T, Trussell J. Determinants of demand: method selection and provider preference among US women seeking abortion services. *Contraception*. 2008 Jun;77(6):397-404. doi: 10.1016/j.contraception.2008.02.003. Epub 2008 Apr 18. PMID: 18477487; PMCID: PMC5515366.

³⁵ Witwer E, Jones RK, Fuentes L, Castle SK. Abortion service delivery in clinics by state policy climate in 2017. *Contracept X*. 2020;2:100043. doi: 10.1016/j.conx.2020.100043. Epub 2020 Oct 16. PMID: 33083783; PMCID: PMC7561526.

³⁶ See, e.g., <https://www.abortionfinder.org/abortion-types/pill-vs-procedure-how-to-decide> (last accessed 1/12/23), <https://www.ucsfhealth.org/education/aspiration-versus-medication-abortion> (last accessed 1/12/23), and <https://floridaabortion.com/2019/03/05/compare-medical-abortion-to-surgical-abortion/> (last accessed 1/12/23).

who have trouble getting time off work, those with COVID-19 concerns, those who are in school, and those who have children or other family members to care for.

43. Naturally, a person may find it more comfortable to have a medication abortion outside of the clinic context, at their own home, at a family member or friend's house, or at some other place of their choosing. Such preferences could be driven by stigma associated with abortion, hostile protestors, or more general preferences to be in an alternative setting with specific people.

44. Surveys of people presenting at clinics providing both surgical and medication abortions—at stages of pregnancy allowing them to have either type—shed light on the frequency with which some of these preferences (besides access) come into play. Noting that people often report multiple reasons and/or have overlapping reasons for choosing a medication abortion: 34 percent report so that it occurs at home,³⁷ 21 percent report emotional reasons,³⁸ 20 percent report a desire to avoid surgery,³⁹ 20 percent report that the medication abortion is less invasive,⁴⁰ 19 percent report that it is less scary,⁴¹ 19 percent report that it feels more natural,^{42,43} 17 percent report that it is safer,⁴⁴ 16 percent report that it is cheaper,⁴⁵ 16 percent report that it is easier,⁴⁶ and 13 percent report that it requires less time at the clinic.⁴⁷

³⁷ Shochet T, Trussell J. Determinants of demand: method selection and provider preference among US women seeking abortion services. *Contraception*. 2008 Jun;77(6):397-404. doi: 10.1016/j.contraception.2008.02.003. Epub 2008 Apr 18. PMID: 18477487; PMCID: PMC5515366.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.*

⁴³ It is not unusual for descriptions of medication abortion to use this terminology as a shorthand for conveying the idea that the process has many similarities with an early miscarriage.

⁴⁴ Shochet T, Trussell J. Determinants of demand: method selection and provider preference among US women seeking abortion services. *Contraception*. 2008 Jun;77(6):397-404. doi: 10.1016/j.contraception.2008.02.003. Epub 2008 Apr 18. PMID: 18477487; PMCID: PMC5515366.

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.*

45. In addition, the American College of Obstetricians and Gynecologists Practice Bulletin explains that a person’s medical conditions could make a medication abortion preferable, including “uterine fibroids that significantly distort the cervical canal or uterine cavity, congenital uterine anomalies, or introital scarring related to infibulation.”⁴⁸

IV. Expected effects of eliminating access to medication abortions

46. As I will discuss in the subsequent sections, eliminating access to medication abortions would likely affect these individuals—and others seeking abortions—by causing further restrictions on an individual’s ability to choose whether, when, and where to have an abortion, which will in turn have material effects on the individual and society.

IV.A. The Unavailability of Medication Abortions Will Increase Waiting Times for Abortion and Other Forms of Care

47. Some of the individuals prevented from obtaining medication abortion from health care providers will end up having no abortion at all, and others will attempt to access abortion through other, less safe means. For some, this will include attempting to self-manage their abortions in the absence of access to a healthcare provider who can provide and counsel the pregnant person with respect to the abortion that the pregnant person needs.

48. Many of the individuals prevented from obtaining medication abortions will seek out surgical abortions. However, many factors will prevent abortion providers from meeting a large and sudden increase in demand for surgical abortions, including infrastructure and staffing.

49. As a result, the increase in demand for surgical abortions is expected to increase waiting times for abortion, which is typical in circumstances in which demand exceeds supply. In evaluating the number of people who will be affected by a restriction on medication abortion, it

⁴⁸ American College of Obstetricians and Gynecologists’ Committee on Practice Bulletins—Gynecology, Society of Family Planning. Medication Abortion Up to 70 Days of Gestation: ACOG Practice Bulletin, Number 225. *Obstet Gynecol.* 2020 Oct;136(4):e31-e47. doi: 10.1097/AOG.0000000000004082. PMID: 32804884.

is important to highlight that this impact will go well beyond the set of individuals who are prevented from obtaining medication abortions. It will affect *all* individuals seeking abortions, since those individuals will all be forced to seek out services from the significantly more limited number of providers who provide surgical abortions and also because providers offering surgical abortions have a limited capacity to provide such abortions.

50. For similar reasons, a surge in demand for surgical abortions could have spillover effects onto people seeking other forms of health care that some practitioners provide in addition to abortion. Abortion providers often also provide other health care services, including contraception, STI screening, clinical breast exams, etc. Given that these providers have constraints on the overall services they can provide (due to infrastructure and staffing), an increase in demand for any one service may strain their ability to provide other services. Thus, individuals who would typically obtain non-abortion care from an abortion provider may be impaired from obtaining such care.

IV.B. Effects of Increased Waiting Times: Delays and Prevented Abortions

51. Increased waiting times at abortion providers can delay or prevent individuals from obtaining abortions.⁴⁹ Increased waiting times can also cause individuals to alter where they obtain an abortion, as they attempt to find alternative providers with shorter waiting times. These effects make individuals worse off (relative to their circumstances if medication abortions are allowed) because the restriction is preventing them from making the choice that they determine is best for them, their health, and their families.

52. Moving beyond the general notion of choice, it is important to highlight that the increased waiting times will likely have devastating financial consequences. Below I will first

⁴⁹ Here and elsewhere I refer to a “delay” as a circumstance in which a person has an abortion later than they would otherwise if medication abortions were still allowed.

discuss how this is the case for individuals who ultimately obtain an abortion and then discuss how this is the case for individuals who continue their pregnancies to childbirth as a result of the increased difficulty of accessing abortion.

53. Most abortion patients across the United States pay out-of-pocket for abortion costs.⁵⁰ In 2020, the median cost of a first-trimester abortion was approximately \$565, but varied across different regions with generally higher costs in the Northeast and the West.⁵¹ The costs of second-trimester surgical abortions vary greatly depending on the gestation of the pregnancy. The overall average cost of a second trimester abortion is \$895, but the average cost is \$2000 later in the second trimester.^{52,53}

54. As a result of these differences, increased waiting times will increase the fees people must pay for an abortion by causing them to get abortions later in pregnancy. A one-day delay can increase fees by \$175.⁵⁴ Increased waiting times, and delays associated with them, may also increase the fees a person must pay by limiting the set of providers from which an individual can obtain care. Moreover, because increased waiting times and delays associated with them typically increase the amount of travel required to obtain a timely abortion, *overall* costs could rise further because of additional costs associated with transportation, childcare, lost wages, or lodging.⁵⁵

⁵⁰ Upadhyay UD, Ahlback C, Kaller S, Cook C, Muñoz I. Trends In Self-Pay Charges And Insurance Acceptance For Abortion In The United States, 2017-20. *Health Aff (Millwood)*. 2022 Apr;41(4):507-515. doi: 10.1377/hlthaff.2021.01528. PMID: 35377750.

⁵¹ *Id.*

⁵² Lindo, J. M., & Pineda-Torres, M. (2021). New Evidence on the Effects of Mandatory Waiting Periods for Abortion. *Journal of Health Economics*, 80, 102533. <https://doi.org/10.1016/j.jhealeco.2021.102533>.

⁵³ See: <https://www.plannedparenthood.org/learn/ask-experts/how-much-does-an-abortion-cost>. (Last accessed December 28, 2022.)

⁵⁴ Lindo, J. M., & Pineda-Torres, M. (2021). New Evidence on the Effects of Mandatory Waiting Periods for Abortion. *Journal of Health Economics*, 80, 102533. <https://doi.org/10.1016/j.jhealeco.2021.102533>.

⁵⁵ A full accounting of travel costs needs to take into consideration direct expenses, child care costs, and lost wages. See, e.g., Lindo, J. M., & Pineda-Torres, M. (2021). New Evidence on the Effects of Mandatory Waiting Periods for Abortion. *Journal of Health Economics*, 80, 102533. <https://doi.org/10.1016/j.jhealeco.2021.102533>.

55. Here it is important to keep in mind that half of the people having abortions have incomes less than the federal poverty line.⁵⁶ Thus, a significant share of people having abortions do not have sufficient incomes to meet their basic needs (such as food, housing, and transportation). Additional expenses, or unexpected expenses, can put individuals in such households in even more perilous positions.

56. Research on the out-of-pocket costs in 2016 indicate that a first-trimester abortion would be classified as a catastrophic health expenditure⁵⁷ for individuals in households earning their state's median income for individuals living in 39 states, and second-trimester abortions would be a catastrophic health expenditure for individuals in households earning their state's median income for individuals living anywhere in the United States.⁵⁸ Given that a substantial majority of people seeking abortions are from low-income households rather than median-income households, the out-of-pocket costs for any type of abortion is likely to be a catastrophic health expenditure for a substantial majority of people seeking abortions.

57. Consistent with these statistics, research has shown that people forgo food and other basic necessities, take out payday and other loans, miss bills and rent, and pawn personal belongings in order to pay for abortions.⁵⁹

58. There are also several non-monetary costs of delays that may be relevant to people seeking abortions. These non-monetary costs include: a heightened risk that their privacy is compromised, which could lead to abuse; psychological distress associated with having to wait; psychological distress associated with a more limited set of provider options (which could

⁵⁶ Jones, *supra* note 6, at 1906.

⁵⁷ See *supra* note 3 (providing definition of "catastrophic health expenditure").

⁵⁸ Zuniga C, Thompson TA, Blanchard K. Abortion as a Catastrophic Health Expenditure in the United States. *Womens Health Issues*. 2020 Nov-Dec;30(6):416-425. doi: 10.1016/j.whi.2020.07.001. Epub 2020 Aug 12. PMID: 32798085.

⁵⁹ *Id.*

affect who is able to be with them before and after an abortion, e.g., if their preferred companion is unable to travel to be with them where they now must go to obtain an abortion); and heightened health risks. Though the major-complication rate for abortion remains low throughout pregnancy, the risks do increase as a pregnancy progresses.⁶⁰

59. These issues may also impose costs on the people who own, operate, and work for businesses that provide abortion care because they restrict their ability to provide care to people in a manner that is consistent with medical judgment about what is the most appropriate method for providing the health care sought. People who work in health care—and other jobs involving the care of others—frequently report that they do so because it is fulfilling to help other people.⁶¹ It is also important to note that “burnout” (e.g., due to a stressful work environment or inadequate staffing)⁶² is frequently cited among those who stop working for health care providers, and heightened stress may occur when abortion providers are operating at their full capacity and trying to expand that capacity, or when they are otherwise forced to provide health care in a manner that does not align with their patients’ needs and preferences. Moreover, for some providers and clinics who only offer medication abortion, eliminating medication abortion would eliminate their ability to provide abortions altogether.

⁶⁰ Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 OBSTETRICS & GYNECOLOGY 175, 181 (2015).

⁶¹ See, e.g., Salyers MP, Rollins AL, Kelly YF, Lysaker PH, Williams JR. Job satisfaction and burnout among VA and community mental health workers. *Adm Policy Ment Health*. 2013 Mar;40(2):69-75. doi: 10.1007/s10488-011-0375-7. PMID: 21972060; PMCID: PMC3980458.

⁶² See, e.g., Shah MK, Gandrakota N, Cimiotti JP, Ghose N, Moore M, Ali MK. Prevalence of and Factors Associated With Nurse Burnout in the US. *JAMA Netw Open*. 2021;4(2):e2036469. doi:10.1001/jamanetworkopen.2020.36469.

IV.C. Effects of Not Being Able to Control the Timing and/or Number of Children Due to Restricted Abortion Access

60. As described above, ceasing to allow medication abortion is likely to prevent some people from obtaining abortions, both people who would prefer a medication abortion and people who would prefer a surgical abortion. This means having a child earlier than they otherwise would and/or having more children than they otherwise would. Each possible outcome involves substantial costs.

61. It is well established that continuing a pregnancy to childbirth poses greater short-term health risks than having an abortion.⁶³ There is also evidence that restricted abortion access increases violence against women,⁶⁴ which is consistent with surveys in which respondents indicate “having an abusive partner” as a reason for seeking an abortion.⁶⁵

62. In terms of the overall economic costs of having a child, some costs are obvious because they involve monetary expenditures, and some are less obvious because they involve lost earnings or impaired earnings potential due to the fact that having a child may mean a person has fewer hours available to work and/or earn income.

63. Expenditures associated with pregnancy and delivery can include medical costs for some individuals (e.g., those who are uninsured) that can be substantial. Other costs besides direct medical expenses include transportation costs and childcare costs associated with medical care and other activities typically done in advance of having a child (such as parenting classes

⁶³ Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215, 216–17 (2012).

⁶⁴ Sarah C. M. Roberts, M. Antonia Biggs, Karuna S. Chibber *et al.*, *Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion*, 12 BMC MED. 144 (2014); Caterina Muratori, *The Impact of Abortion Access on Violence Against Women*, (Department of Economics, University of Reading, Working Paper No. 2021-03, 2021).

⁶⁵ See, e.g., Karuna S. Chibber, M Antonia Biggs, Sarah C. M. Roberts & Diana Greene Foster, *The role of intimate partners in women's reasons for seeking abortion*, WOMENS HEALTH ISSUES, (2014); M Antonia Biggs, H. Gould & Diana Greene Foster, *Understanding why women seek abortions in the US*, 13 BMC WOMEN'S HEALTH 29 (2013).

and purchasing equipment/materials that are necessary for the child's wellbeing and safety).

These costs—particularly at a time when a new member is being added to the household—can push individuals further into poverty.

64. Child-rearing expenses include housing, food, transportation, clothing, health care, childcare, and many miscellaneous expenses. These costs typically exceed \$9,000 annually, even for low- and middle-income households.⁶⁶ As I described above, a substantial share of individuals seeking abortion are already in poverty. Adding a child to such a household without substantially expanding their resources will thrust such an individual deeper into poverty. Given the highly persistent nature of economic circumstances, this is likely to affect the individual for their entire life.

65. In addition, time-costs associated with pregnancy, childbearing, and childrearing can make it difficult for people to continue in school, to make other investments in their careers, to work as many hours as they would like, to maintain jobs, to look for work, etc. Any of these things can deplete an individual's financial resources in the short run and in the long run.

66. In sum, monetary costs and time-costs (associated with pregnancy, childbearing, and childrearing), are so substantial that they could cause significant and persistent economic harm by putting an individual on an entirely different life course in which they have more limited resources (possibly on top of having another child to provide for).

67. Many carefully designed studies have quantified such effects using different approaches to data analysis, using different data sets, etc. and examining different contexts, different populations, and different outcomes.⁶⁷

⁶⁶ Mark Lino et al. "Expenditures on Children by Families, 2015" UNITED STATES DEPARTMENT OF AGRICULTURE, CENTER FOR NUTRITION POLICY AND PROMOTION MISCELLANEOUS REPORT NO. 1528-2015 (2017).

⁶⁷ For studies documenting effects on economic outcomes, *see, e.g.*, Aguero, Jorge M., and Mindy S. Marks, 2008 "Motherhood and Female Labor Force Participation: Evidence from Infertility Shocks." *The American Economic*

68. One such study, which used cutting-edge methods for estimating causal effects to estimate the effects on economic outcomes, found that being denied an abortion increased financial distress in all five years of their five-year follow-up period.⁶⁸ The analyses aimed at better understanding this effect on financial distress indicated that being denied an abortion increased a person's amount of past-due debt by an average of \$1,750, increased the number of negative public records on their credit reports (such as bankruptcy, evictions, and tax liens) by 81 percent, and reduced their income by 6 percent.⁶⁹

69. Researchers have also examined how state policy changes altering abortion access affected the socioeconomic outcomes for the general population of women in the state, which can be measured using very large data sets. Studies examining the effects of bans on abortion show deleterious effects on residents' educational attainment and economic outcomes (including employment, earnings, family income, poverty, and public assistance receipt), particularly among Black women.⁷⁰ Along similar lines, research on the effects of impaired access to abortion resulting from state targeted-regulations on abortion providers ("TRAP Laws") also show deleterious effects on educational attainment, particularly among Black women.⁷¹

70. To put the estimated effects on educational attainment into context, it is important

Review, 98(2): 500-504; Adda, Jerome, Christian Dustmann, and Katrien Stevens, 2017, "The Career Costs of Children," *Journal of Political Economy*, 125(2): 293-337; Kleven, Henrik, Camille Landais, and Jakob Egholt Sogaard. 2019, "Children and Gender Inequality: Evidence from Denmark," *American Economic Journal: Applied Economics*, 11(4): 181-209; Sandler, Danielle, and Nichole Szembrot, 2019, "Maternal Labor Dynamics: Participation, Earnings, and Employer Changes," U.S. Census Bureau Center for Economic Studies Working Paper No. CES 19-33, Washington, DC.

⁶⁸ Sarah Miller et. al., *Economic Consequences of Being Denied an Abortion*, Am. ECON. J.: ECON. POL'Y, (Forthcoming) 1, 5 (2021).

⁶⁹ *Id.* at 4.

⁷⁰ Joshua D. Angrist & William N. Evans, *Schooling and Labor Market Consequences of the 1970 State Abortion Reforms*, 18 RSCH. IN LAB. ECON. 75, 75-113 (2000); Jason M. Lindo et al., *Legal Access to Reproductive Control Technology, Women's Education, and Earnings Approaching Retirement*, 110 AEA PAPERS & PROC. 231, 234 (2020); Kelly Jones, *At a Crossroads: The Impact of Abortion Access on Future Economic Outcomes*, (Am. Univ., Working Paper No. 2021-02, 2021), <https://doi.org/10.17606/0Q51-0R11>.

⁷¹ *Id.*

to keep in mind that the benefits of education are likely to go well beyond wages. As Oreopoulos and Salvanes write in their summary of the literature on the non-pecuniary benefits of education: “Gains from school occur from being in a job that not only pays more but also offers more opportunities for self-accomplishment, social interaction, and independence. Schooling generates occupational prestige. It reduces the chance of ending up on welfare or unemployed. It improves success in the labor market and the marriage market. Better decision-making skills learned in school also lead to better health, happier marriages, and more successful children. School also leads to better health, happier marriages, and more successful children. Schooling also encourages patience and long-term thinking. Teen fertility, criminal activity, and other risky behaviors decrease with it. Schooling promotes trust and civic participation. It teaches students how to enjoy a good book and manage money. And for many, schooling has consumption value too.”⁷²

71. As noted above, a majority of those obtaining abortions have previously given birth, and people seeking abortions often report that they are doing so out of concern for their existing children. In addition, many individuals will go on to have children later in their lives after they have had an abortion. As such, the lives of these children will also be altered by the impacts on their parents described above.

72. More limited economic resources can result in detrimental effects on children’s behavioral and emotional issues,⁷³ and on test scores,⁷⁴ which can lead to grade repetition.

⁷² Philip Oreopoulos & Kjell G. Salvanes, *Priceless: The Nonpecuniary Benefits of Schooling*, 25 J. OF ECON. PERSP. 159, 159-84 (2011).

⁷³ See, e.g., Randall Akee, William Copeland, E. Jane Costello, & Emilia Simeonova, *How Does Household Income Affect Child Personality Traits and Behaviors?*, 108 AM. ECON. REV. 775, 775-827 (2018); Kevin Milligan & Mark Stabile, *Do Child Tax Benefits Affect the Well-Being of Children? Evidence from Canadian Child Benefit Expansions*, 3 AM. ECON. J.: ECON. POL’Y 175, 175-205 (2011).

⁷⁴ See, e.g., Sandra E. Black, Paul J. Devereux, Katrine V. Løken & Kjell G. Salvanes, *Care or Cash? The Effect of Child Care Subsidies on Student Performance*, 96 REV. OF ECON. AND STAT. 824, 824-37 (2014); Gordon B. Dahl & Lance Lochner, *The Impact of Family Income on Child Achievement: Evidence from the Earned Income Tax Credit*,

Economic circumstances during childhood also have long-run effects which show up in educational attainment and adult earnings,⁷⁵ as well as measures of earnings capacity, economic self-sufficiency, neighborhood quality, and life expectancy.⁷⁶ Along similar lines, parental education affects children's health at birth,⁷⁷ cognitive skills and behavioral problems in childhood,⁷⁸ the probability of repeating a grade,⁷⁹ and involvement in crime.⁸⁰

IV.D. Effects on Society More Broadly

73. The issues described above, which would result from eliminating access to medication abortion, pertain to the lives of the individuals seeking abortion, their families, *and the broader public*.

74. Among the issues not touched on above, it bears mentioning that any decision that reduces access to medication abortion, and ultimately denies abortions to individuals who want them, will generally increase health care costs via the costs of health care during pregnancy, childbearing, and beyond. All of these costs can be extremely high, particularly when health complications arise.

75. Health care costs are a societal issue because of many unique features of the industry, including health insurance. For private insurance, rates are set according to the costs

102 AM. ECON. REV. 1927, 1927–56 (2012); Kevin Milligan, & Mark Stabile, *Do Child Tax Benefits Affect the Well-Being of Children? Evidence from Canadian Child Benefit Expansions*, 3 AM. ECON. J.: ECON. POL'Y 175, 175–205 (2011).

⁷⁵ Andrew Barr, Jonathan Eggleston & Alexander A. Smith, *Investing in Infants: The Lasting Effects of Cash Transfers to New Families*, THE Q. J. OF ECON., (2022).

⁷⁶ Martha J. Bailey, Hilary Hoynes, Maya Rossin-Slater & Reed Walker, *Is the Social Safety Net a Long-Term Investment? Large-Scale Evidence from the Food Stamps Program*, (Nat'l Bureau of Econ. Rsch., Working Paper No. 26942, 2020).

⁷⁷ Janet Currie & Enrico Moretti, *Mother's Education and the Intergenerational Transmission of Human Capital: Evidence from College Openings*, 118 Q. J. OF ECON. 1495, 1495–532 (2003).

⁷⁸ Pedro Carneiro, Costas Meghir & Matthias Parey, *Maternal Education, Home Environments, and the Development of Children and Adolescents*, 11 J. OF THE EUR. ECON. ASS'N 123,123–60 (2013).

⁷⁹ Philip Oreopoulos, Marianne E. Page & Ann Huff Stevens, *The Intergenerational Effects of Compulsory Schooling*, 24 J. OF LABOR ECON. 729, 729–60 (2006).

⁸⁰ Aaron Chalfin & Monica Deza, *The intergenerational effects of education on delinquency*, 159 J. OF ECON. BEHAV. & ORG. 553, 553–71, (2019).

associated with the set of individuals who are being insured (i.e., the risk pool). Thus, if the costs increase for any subset of those individuals (e.g., those being delayed or prevented from obtaining an abortion legally), it increases the rate for *everyone* being insured.

76. Similarly, a (much) broader set of individuals is affected by increases in health care costs for individuals on public health insurance. In that regard, increases in health care costs (e.g., from individuals being delayed or prevented from obtaining an abortion legally) will increase the costs imposed on taxpayers.

77. It is worth noting here that the number of people on public health insurance is likely to increase if medication abortion is no longer available as a result of the economic effects described above, which will additionally affect taxpayers. Those economic effects will also affect taxpayers by increasing the need for other public assistance and social safety net programs (including food stamps, housing assistance, tax credits, and other programs and services).

78. Moreover, the effects on people seeking abortion and on their children are likely to affect many other people's lives in many other ways.⁸¹ A rich literature shows that people have significant impacts on the lives of others through family and friendship networks, neighborhoods, schools, and many other channels. Moreover, it is clear from this literature that the effect of poverty—which will be increased if medication abortion ceases to be available—is pervasive.

79. Further, researchers talk about “poverty traps” because it is so difficult to escape poverty⁸² and “intergenerational poverty” because of the high degree to which poverty persists

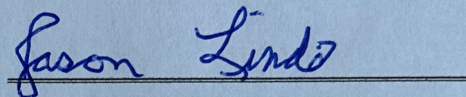
⁸¹ See, e.g., Diana Greene Foster, *The Turnaway Study: Ten Years, a Thousand Women, and the Consequences of Having—or Being Denied—an Abortion* (2020).

⁸² See, e.g., Bowles, Samuel, Durlauf, Steven N. and Hoff, Karla. *Poverty Traps*, Princeton: Princeton University Press, 2006. <https://doi.org/10.1515/9781400841295>.

from one generation to the next.⁸⁴ Research on these topics indicates that effects on poverty can be expected to last throughout individuals' lives and into subsequent generations.

80. For all of these reasons, eliminating access to medication abortion will impose severe costs on many individuals and society as a whole, both in the short term and for future generations, as well as healthcare delivery systems across the country.

Executed January 13, 2023

A handwritten signature in blue ink that reads "Jason Lindo". The signature is written in a cursive style and is positioned above a horizontal line.

Jason Lindo, Ph.D.

⁸⁴ See, e.g., Harper, Caroline, Rachel Marcus, and Karen Moore. "Enduring Poverty and the Conditions of Childhood: Lifecourse and Intergenerational Poverty Transmissions." *World Development* 31, 2003.

EXHIBIT A

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CURRENT POSITIONS

Professor of Economics, Texas A&M University, 2018–Present
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Research Associate, National Bureau of Economic Research (NBER), 2014–Present
Research Fellow, Institute for the Study of Labor (IZA), 2010–Present
Co-Editor, *Economic Inquiry*, 2016–Present

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Associate Editor, *Journal of Population Economics*, 2016–2022
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EDUCATION

Ph.D., Economics, University of California, Davis, 2009
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RESEARCH INTERESTS

reproductive health, health behaviors and outcomes, employment shocks and family dynamics, youth, crime

TEACHING INTERESTS

Econometric/Empirical Methods; Health (Care, Behavior, Outcomes); Labor; Gender; Demography

PUBLICATIONS

Peer-Reviewed Publications

Lindo, Jason M., Isaac D. Swensen, and Glen R. Waddell. "Effects of Violent Media Content: Evidence from the Rise of the UFC," *Journal of Health Economics*, forthcoming.

Lindo, Jason M. [Ⓢ] Mayra Pineda-Torres. "New Evidence on The Effects of Mandatory Delay Laws for Abortion," *Journal of Health Economics*, 80, 2021.

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- Bullinger, Lindsey Rose, Jason M. Lindo, and Jessamyn Schaller. **"Economic Determinants of Child Maltreatment,"** in Alain Marciano and Giovanni Battista Ramello, eds., *Encyclopedia of Law and Economics, Second Edition*, 2021.
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- Bailey, Martha J. and Jason M. Lindo. **"Access and Use of Contraceptives and Its Effects on Women's Outcomes in the United States,"** in Susan L. Averett, Laura M. Argys, and Saul D. Hoffman, ed., *Oxford Handbook on the Economics of Women*, New York: Oxford University Press, 2018.
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Cao, Andy, Jason M. Lindo, and Jiee Zhong. **“Can Social Media Rhetoric Incite Hate Incidents? Evidence from Trump’s “Chinese Virus” Tweets,”** NBER Working Paper No. 30588.

GRANTS AND COMPETITIVE EXTERNAL FELLOWSHIPS

Laura and John Arnold Foundation, PI, 2018 (\$66,710)

National Institute for Health Care Management Research and Education Foundation, PI, 2017

Turnovsky Fellowship, 2017

US Department of Justice Research Grant, Co-PI with Isaac D. Swensen, Award 2014-R2-CX-0015, 2014

INTERNAL GRANTS

Texas Census Research Data Center Proposal Development Grant, 2014

Texas Census Research Data Center Proposal Development Grant, 2013

Center for the Study of Women in Society Faculty Research Grant, University of Oregon, 2012

Junior Professorship Development Grant, University of Oregon, College of Arts and Sciences, 2011
 Junior Professorship Development Grant, University of Oregon, College of Arts and Sciences, 2010
 Junior Faculty Award, University of Oregon, 2009
 Graduate Student Travel Award, UC Davis, 2007

HONORS AND AWARDS

Best Supporter of Graduate Students, Texas A&M Department of Economics, 2020
 Outstanding Graduate Instructor of the Year, Texas A&M Department of Economics, 2018
 Best Graduate Advisor, Texas A&M Department of Economics, 2017
 Outstanding Graduate Instructor of the Year, Texas A&M Department of Economics, 2013
 Emerging Scholar, Center for Poverty Research, University of Kentucky, 2011
 Phi Beta Kappa, 2005

INVITED PRESENTATIONS AND WORKSHOPS

2022–2023 (including planned): Texas A&M University (Dept of History’s roundtable about Dobbs v. Jackson Women’s Health Organization), Economists’ Perspectives on Abortion Access (American Society of Health Economists’ Special Event), Vanderbilt Law School Law and Economics Workshop

2021–2022: Elon University, University of Connecticut, Essen Health Conference (keynote)

2020–2021: Centre for Health Economics–Monash Business School, Monash University Department of Economics, Association for Mentoring & Inclusion in Economics (AMIE)

2019–2020: Miami University, Indiana University, San Diego State University, Society of Family Planning Annual Meeting, American Economic Association Annual Meetings, University of Michigan, University of South Florida

2018–2019: 3rd IZA Workshop on Gender and Family Economics, University of California at Davis, Brookings Conference on Improving Opportunity Through Family Planning

2017–2018: University of Kansas, Stata Texas Empirical Micro Conference, Sam Houston State University, Ifo Institute Workshop on Economic Uncertainty and the Family, 18th Annual Southeastern Health Economics Study Group, University of Tennessee, Texas A&M University (Agricultural Economics), Birdsall House Conference on Women (Center for Global Development), Texas A&M University (School of Public Health), University of South Carolina, Columbia University, American University, NBER Health Economics Program Meetings, University of California at Davis, Montana State University Initiative for Regulation and Applied Economic Analysis Conference on “Economics of Reproductive Health Policies”

2016–2017: Montana State University, University of Colorado at Boulder, West Virginia University, Fall Meetings of the Association for Public Policy Analysis & Management, Annual Meetings of the American Economics Association, University of California at Merced, Southern Methodist University, Victoria University of Wellington

2015–2016: Texas Tech University, Southern Economic Association Annual Meetings, National Institute for Health Care Management Webinar on Adolescent Health and Teen Pregnancy, NBER Children’s Program Meetings, China Meeting of the Econometric Society

2014–2015: Monash University, University of North Carolina at Charlotte, Baylor University, SOLE/EALE World Meetings

2013–2014: Tulane University, University of Texas at Dallas, Dalhousie University, University of Houston and Rice University, University of Wollongong, Victoria University of Wellington, Massey University

2012–2013: Labour Econometrics Workshop (Discussant), University of Wollongong, Texas A&M University, University of Illinois at Urbana-Champaign, Louisiana State University, Michigan State University, University of California at Merced, 5th Annual Meeting on the Economics of Risky Behaviors, NBER Children’s Program Meetings

2011–2012: The Australian National University, University of Wollongong, Australian Labour Econometrics Workshop, University of Notre Dame, Case Western Reserve University, University of Maryland, University of Oregon,

SOLE Annual Meetings, IZA/SOLE Transatlantic Meeting of Labor Economists

2010–2011: NBER Children’s Program Meetings, SOLE Annual Meetings, Public Policy and the Economics of the Family Conference at Mount Holyoke College, University of Kentucky, Portland State University

2009–2010: Western Economic Association Annual Meetings, American Economic Association Annual Meetings (Discussant), SOLE/EALE World Meetings, The Economics of Family Policy Conference at the University of Bergen, NBER Children’s Program Meetings, Economic Demography Workshop, University of British Columbia

2008–2009: NBER Higher Education Program Meetings, RAND Corporation, University of Colorado at Denver, Stanford Institute for Economic Policy Research, University of Oregon, The College of William and Mary, Sonoma State University, California State University at Sacramento, All UC Labor Conference, UC Davis Economy, Justice, and Society Retreat, Western Economic Association Annual Meetings

ADDITIONAL PROFESSIONAL ACTIVITIES

Co-Director of Mentoring: Association for Mentoring & Inclusion in Economics (AMIE), 2021–Present

Referee: *American Economic Journal: Applied Economics, American Economic Journal: Economic Policy, American Economic Review, American Journal of Health Economics, American Journal of Obstetrics and Gynecology, The B.E. Journal of Economic Analysis and Policy, Children and Youth Services Review, Contemporary Economic Policy, Contraception, Demography, Eastern Economic Journal, The Economic Journal, Economics of Education Review, Economic Inquiry, Education Evaluation and Policy Analysis, Empirical Economics, Health Economics, Industrial and Labor Relations Review, Institute for Women’s Policy Research, Journal of Applied Econometrics, Journal of Econometrics, Journal of Family and Economic Issues, Journal of Health Economics, The Journal of Human Resources, Journal of The Japanese and International Economies, Journal of Labor Economics, Journal of Labor Research, Journal of Law Economics and Organization, Journal of Policy Analysis and Management, Journal of Political Economy, Journal of Population Economics, Journal of Public Economics, Journal of the Royal Statistical Society, Labour Economics, Proceedings of the National Academy of Sciences, Public Choice, The Quarterly Journal of Economics, Review of Economics of The Household, Review of Economic Studies, The Southern Economic Journal, Women’s Health Issues*

Reviewer: National Science Foundation, APPAM Program Committee

Co-organizer or Committee Member: Montana State University Initiative for Regulation and Applied Economic Analysis Conference on “Economics of Unemployment Insurance” 2020 (Co-organizer), Texas Health Economics Workshop 2019 (Co-organizer), Montana State University Initiative for Regulation and Applied Economic Analysis Conference on “Economics of Reproductive Health Policies” 2018 (Co-organizer), Annual Health Economics Conference 2018 (Committee Member), Economic Demography Workshop 2018 (Committee Member), Midwestern Econometrics Group Meetings 2017 ((Committee Member), Economic Demography Workshop 2017 (Committee Member), 15th Annual Labour Econometrics Workshop 2012 (Committee Member)

Advisory Board Member: Michigan Contraceptive Access, Research, and Evaluation Study, 2018–Present

TEACHING EXPERIENCE

Texas A&M University

Introduction to Economic Data Analysis (planned Spr 23)

Program/Policy Evaluation (Fall 14, Spr 14, Spr 16, Spr 17, Spr 18, Fall 19, Fall 20, Spr 21, Spr 22, planned Spr 23)

PhD-level Econometrics (Fall 13, Fall 14, Spr 15, Spr 16, Spr 17, Spr 18, Spr 19, Spr 21, Spr 22)

Shanghai University of Finance and Economics

Short Course in Econometric Methods for Causal Inference (Summer 16)

University of Oregon

Graduate Labor Economics (Winter 10, Fall 10, Spr 13)

Topics in Labor Economics (Fall 09, Winter 10, Fall 10, Spr 11, Fall 11, Spr 12, Spr 13)

Economics of Gender (Spr 11, Fall 11, Spr 12)

PHD STUDENT ADVISING (including graduation year and initial placement)**Texas A&M University**

Jing Zhang (in progress)
 Maxwell Bullard (co-chair, in progress)
 Jiee Zhong (co-chair, in progress)
 Wesley Miller (in progress)
 Andre'nay Harris (in progress)
 Mayra Pineda Torres (chair, 2022), Georgia Tech University
 David Pritchard (chair, 2022), U.S. Census Bureau
 Hedieh Tajali (2022), University of Edinburgh
 Andrea Kelly (chair, 2020), Grinnell College
 Manuel Hoffman (2020), University of Heidelberg
 Joshua Witter (2020), Correlation Research Division at the Church of Jesus Christ of Latter-Day Saints
 Roberto Mosquera (co-chair, 2019), Universidad de las Américas
 Brittany Street (2019), University of Missouri
 John Anders (2019), US Census Bureau
 Ruichao Si (2019), Nankai University
 Samuel Bondurant (chair, 2018) US Census Bureau
 Abigail Peralta (2018), Louisiana State University
 Yongzhi Sun (2018), Southwestern University of Finance and Economics
 María Padilla-Romo (chair, 2017), University of Tennessee
 Emily Zheng (chair, 2017), Chinese University of Hong Kong - Shenzhen
 Jaegum Lim (2017), Korean National Assembly
 Analisa Packham (chair, 2016), Miami University
 Pierre Mouganie (2015), American University of Beirut
 Jillian Carr (2015), Purdue University

University of Oregon

Kristian Holden (co-chair, 2014), American Institutes for Research (AIR)
 Harold Cuffe (co-chair, 2013), Victoria University of Wellington
 Isaac Swensen (co-chair, 2013), Montana State University
 Brian Vander Naald (2012), University of Alaska, Juneau
 Eric Duquette (2010), Economic Research Service, USDA

UNIVERSITY SERVICE

Faculty Senate, 2014-2016
 Climate and Diversity Committee, 2015-2016
 Academic Affairs Committee, 2014-2015

DEPARTMENTAL SERVICE**Texas A&M University**

Graduate Instruction Committee, 2021–2022
 Junior Faculty Mentor, 2021–2022
 Econometrics Search Committee, 2019–2021
 Economics Department Head Search Committee, 2019–2020
 PERC Applied Microeconomics Workshop Co-organizer, 2019–2020

Organizer, Inaugural Public Labor and Industrial Organization (PLIO) Alumni Conference, 2019
 Graduate Placement Co-director, 2013–2014, 2015–2016, 2017–2018, 2018–2019
 Economics Undergraduate Research Opportunities Program Advisor, 2014–2015, 2018–2019
 Executive Committee, 2017–2018
 Graduate Instruction Committee, 2017–2018
 Applied Microeconomics Search Committee Chair, 2014–2015
 Applied Microeconomics Search Committee, 2013–2014

University of Oregon

McNair Scholar Advisor, 2012–2013
 Graduate Placement Co-director, 2010–2012
 Undergraduate Program Committee, 2009–2013
 Seminar Committee, 2009–2010
 Applied Microeconomics Brownbag Co-organizer, 2009–2010

SELECTED MEDIA APPEARANCES AND COVERAGE

Television:

"Economists warn about effects of abortion restrictions," Spectrum News 1, 5/19/22
 "Rape on College Campuses," Not Safe with Nikki Glaser (Comedy Central), 7/12/16
 "College Football and Campus Sexual Assault," Outside The Lines (ESPN), 2/19/16
 "College Game Day's Disturbing Trend," Watching the Hawks (RT), 1/11/16

Radio/Podcast:

"With Roe v. Wade overturned, economic disparities are poised to get worse," Marketplace, 6/24/22
 "Women who are denied abortions risk falling deeper into poverty," Morning Edition (NPR), 5/26/22
 "Episode 33: Persistent Effects of Violent Media Content," Probable Causation, 8/4/20
 "Persistent Effects of Violent Media Content," Vox's The Weeds, 5/26/20 (46th minute)
 "The benefits of IUDs," Vox's The Weeds, 3/26/19 (37th minute)
 "What happens when abortion providers shut down," Vox's The Weeds, 5/3/17 (50th minute)
 "Is There a Connection Between Football Games and Risks For Rape?" Morning Edition (NPR), 2/17/16

Print:

"Update: Judge has ruled abortions can continue in Kentucky for now," ABC 36, 7/22/22
 "Roe Stood for 49 Years. It Revolutionized Life for Women," 6/24/22, Wired
 "Study Finds Reduced Involvement In Violent Crime For UFC Viewers," 5/20/22, MMA News
 "5 ways abortion bans could hurt women in the workforce," 5/19/22, Vox
 "UFC mixed martial arts fighting events appear to reduce involvement in violent crime," 5/18/22, PsyPost
 "Limiting abortion access is bad for the economy," 5/16/22, CNN
 "When SafeGraph pulled abortion clinic data..." 5/13/22, Protocol
 "Sensemaker: Who abortion bans hurt," 5/12/22, Tortoise Media
 "Roe v. Wade isn't just about women's rights. The economic implications..." 5/7/22, Business Insider
 "Abortion Rollback Risks Erasing Decades of Economic Gains for U.S. Women," 5/4/22, Bloomberg
 "Being Denied an Abortion Has Lasting Impacts on Health and Finances," 12/22/21, Scientific American
 "Texas abortion ban is an early glimpse of what post-Roe America would look like for women," 5/18/21, CNN
 "Where Abortion Access Would Decline if Roe v. Wade Were Overturned," 5/18/21, The New York Times
 "What History Says Will Happen Next in Iran," 1/7/20, The Atlantic
 "How To Reduce Abortion," 10/17/19, New York Times

"Why America's Abortion Rate Might Be Higher Than It Appears," 9/20/19, New York Times
 "Tennessee's abortion wait period law faces court arguments," 9/20/19, Associated Press (reprinted worldwide)
 "Mandatory waiting periods can make abortions nearly \$1,000 more expensive," 9/10/19, MarketWatch
 "Could expanding access to contraception improve economic outcomes?" 8/29/19, PBS News Hour
 "Judge blocks new Arkansas abortion laws just before midnight," 7/24/19, Arkansas Democrat Gazette
 "Where Roe v. Wade Has the Biggest Effect," 7/18/19, New York Times
 "Former Gov. Hickenlooper unveils plan to expand access to women's contraception," 5/29/19, ABC News
 "Colorado teen pregnancies dropped 20% near these clinics...funding is at risk," 3/22/19, Denver Post
 "Better access to IUDs drove a 20% drop in teen pregnancy and abortions, report finds," 3/18/19, Daily Mail
 "One Abortion Clinic Remains Open In Missouri, Following New State Requirements," 10/3/18, NPR
 "Do campus rape investigations damage colleges? Actually, the opposite may be true," 7/25/18, Salon
 "Study finds home football games elevate cases of sexual assault" 2/1/18, The Battalion.
 "Abortion Clinics in Texas Haven't Reopened, and It's Causing Real Damage to Real Women," 5/3/17, Salon
 "The IUD Revolution," 3/23/16, Vox
 "Will Nabbing of 'El Chapo' Actually Help Mexico Win the War on Drugs?" 1/23/16, Newsweek
 "El Chapo Shows The Folly of the War on Drugs," 1/21/16, Time
 "Less Rape On Campus? Get Rid of College Football," 1/7/16, US News and World Report
 "Report: Rape Rates at Big Football Colleges Spike on Game Day," 1/16, CBS News
 "What We Can Learn From That Paper About Campus Rape on Game Days," 12/15, Slate
 "The Disturbing Truth About College Football and Rape," 12/2015, The Washington Post
 "College Football, Parties and Rape," 12/2015, Inside Higher Ed
 "With Less Money, Colorado's Birth Control Program Feels the Pain," 8/2015, The Denver Post
 "Does Child Abuse Rise During a Recession?" 5/2013, Freakonomics.com
 "Ticket to Drink Opens Door to Health Woes," 3/2013, Illawara Mercury
 "How Does Football Success Affect Student Performance?" 10/2012, The Chronicle of Higher Education
 "Rethinking The Benefits of College Athletics," 3/2012, Forbes
 "How Big-Time Sports Ate College Life," 1/2012, New York Times
 "College Football Victories = Worse Grades?" 1/2011, Freakonomics.com
 "Study Links Winning Football and Declining Grades," 1/2011, New York Times
 "Football Team Wins, Grades Plummet," 12/2011, The Wall Street Journal
 "Study: Male Students' Grades Drop When Football Teams Win," 12/2011, USA Today
 "Winning Football, Declining Grades," 12/2011, Inside Higher Ed
 "Study: As Ducks Win, Male Grades Drop," 12/2011, ESPN
 "Guys' Grades Suffer When College Football Teams Win," 12/2011, The Atlantic
 "Academic Probation Hits College Guys Harder," 5/2010, Science Daily

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